Health Services
LOS ANGELES COUNTY

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To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.

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May 14, 2013

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

APPROVAL OF AMENDMENTS TO TWO AGREEMENTS FOR FINANCIAL MANAGEMENT SERVICES AND FINANCIAL BILLING AND RECOVERY SERVICES
(ALL SUPERVISORIAL DISTRICTS)
(3 VOTES)

SUBJECT

Request approval of amendments to extend the term of agreements with Sutherland Global Services, formerly Apollo Health Street, Inc., for Financial Management Services and USCB America for Financial Billing and Recovery Services for the Department of Health Services.

IT IS RECOMMENDED THAT THE BOARD:

1. Authorize the Director of Health Services (Director), or his designee, to execute Amendment No. 3 to the Financial Management Services (FMS) Agreement No. H-703466 with Sutherland Global Services (SGS), effective upon approval by the Board, to extend the term of the Agreement for the period June 1, 2013 through May 31, 2015 with a reduction in compensation rates and with an option to further extend the Agreement term on an annual basis for up to two additional years through May 31, 2017 at additional reduced compensation rates, with the exercise of such options subject to Board approval.

2. Authorize the Director, or his designee, to execute Amendment No. 4 to the Financial Billing and Recovery Services (FBRS) Agreement, No. H-702058, with USCB America (USCB), effective upon approval by the Board, to extend

the term of the Agreement for the period June 1, 2013 through May 31, 2015 and with an option to further extend the Agreement term on an annual basis for up to two additional years through May 31, 2017 at additional reduced compensation rates, with the exercise of such options subject to Board approval.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

Approval of the first two recommendations will allow the Director, or his designee, to execute amendments substantially similar to Exhibits I and II to extend the term of the Agreements with SGS and USCB for the period June 1, 2013 through May 31, 2015. In addition, the recommended amendments for SGS and USCB provide reduced compensation rates for the County which is estimated to result in savings of approximately $0.2 million and $0.4 million from SGS and USCB, respectively, for the two year period. Both Agreements are slated to expire May 31, 2013.

The recommended amendments also include the option to extend the term of the Agreements for up to two additional one-year periods beginning June 1, 2015 through May 31, 2017, and further reduce the compensation rates which is estimated to result in savings of approximately $0.5 million and $0.4 million from SGS and USCB, respectively. The Department of Health Services (DHS or the Department) will return to the Board for approval to exercise the options in the event the Department determines further extensions are in the best interest of the County.

The Board was previously advised last year that DHS intended to issue a single Request for Proposals (RFP) with the goal of securing one or more successor agreements to replace the current SGS and USCB Agreements and provide the full range of revenue recovery services to the Department. True to that commitment, RFPs for FMS and Safety Net Financial Management Services were released in February 2013. DHS realized that it was necessary to subsequently cancel both solicitations due issues raised by potential proposers about the structure of the RFPs as well as the timing of a number of critical and transformative projects DHS is engaged in as we prepare for implementation of the Affordable Care Act (ACA) (e.g., itemized billing conversion for hospitals and clinics, physicians and specialty care, centralization of various processes and tasks to the Consolidated Business Office, ICD-9 to ICD-10 conversion, and implementation of the recently approved Online Real-time Centralized Health Information Database (ORCHID) System [Electronic Health Records (EHR)]. These overlapping projects hold many uncertainties. The recommended Agreement extensions will provide sufficient time to determine the long term scope of FMS needs the County will experience under ACA and implementation of ORCHID and enable DHS to determine the most effective method of packaging the solicitations to meet those needs.

Approval of the recommended actions will ensure the continued and uninterrupted services for FMS and FBRS and safeguard the Department's anticipated revenue collections. Failure to execute the recommended actions may jeopardize annual revenue of approximately $732.6 million for DHS in patient care billing, totaling $2,930.4 million for the four year period.

Implementation of Strategic Plan Goals

The recommended actions support Goal 1, Operational Effectiveness, and Goal 2, Fiscal Sustainability, of the County's Strategic Plan.

FISCAL IMPACT/FINANCING

Both SGS and USCB receive a contractual fee based on actual collections received by the County resulting from their services. The recommended actions will allow DHS to achieve estimated annual revenue collection of approximately $732.6 million, totaling $2,930.4 million from June 1, 2013 through May 31, 2017.

The total estimated annual fee is approximately $ 8.6 million, which includes $7.3 million for SGS and $1.3 million for USCB. The total estimated fee for the four year extension is approximately $34.4 million, which includes $29.2 million for SGS and $5.2 million for USCB.

Funding is included in the DHS Fiscal Year (FY) 2012-13 Final Budget and FY 2013-14 Recommended Budget. Additional funding will be requested in future fiscal years, as needed.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

SGS Agreement:

Under the current Agreement, SGS provides a wide range of financial management services including data mining and capturing, Billing and Follow-up Services, Financial Management and Consulting Services, and Secondary Third-Party Resource Identification and Recovery Services at DHS hospitals, Health and Comprehensive Health Centers, and Multi-Service Ambulatory Care Centers to maximize revenue recovery as well as assist DHS to maximize cost report reimbursements. Subsequent amendments provided increased compensation if certain baseline collections were attained. As a result, SGS has increased collections on an annual basis.

SGS has the ability to make use of its enhanced data capturing, processing and claiming programs in order to fulfill the exceptional and fluctuating requirements of the County. Its customized on-site billing remains an essential part of the billing process which continues to allow DHS facilities to directly bill claims to all payers in compliance with federal, state and local regulations.

In FY 2012-13, SGS is estimated to generate $149.1 million in annual gross revenue and total estimated fee is $6.9 million, for a net revenue collection of approximately $142.2 million. These are estimates prior to anticipated savings from the extension period.

Additionally, as the Department's billing clearinghouse, DHS is estimated to generate approximately $579.3 million in FY 2012-13 by using SGS' customized system. The estimated fees for these services are approximately $0.4 million, for a net revenue collection of $578.9 million.

The recommended amendment will replace the current Statement of Work in its entirety to include the County's requirements and add the following key provisions to the FMS Agreement:

(1) Provision for Underpaid Account Identification and Recovery Services allowing the County to refer closed and potential underpaid accounts to the vendor for additional recovery efforts.

(2) Provision requiring the vendor to review accounts with credit balances to ensure payments are correct and take appropriate actions to refund overpayments.

(3) Provisions for Performance Requirements including monetary penalties if specific deliverables

are not met.

The inclusion of the above provisions to the FMS agreement will complement existing services which is anticipated to improve revenue collection and effectiveness of services currently provided.

USCB Agreement:

Under the current Agreement, USCB continues to work closely with DHS to provide third party identification and billing services that are compliant with state, federal and other payer requirements. Throughout this process, USCB has established the experience and working relationship necessary to continue to effectively provide the services required to support DHS' large and complex billing operations.

In FY 2012-13, USCB is estimated to generate $12.8 million in annual gross revenue and total estimated fee is $1.3 million, for a net revenue collection of $11.5 million. These are estimates prior to anticipated savings from the extension period.

Both Agreements:

Account referrals made to each Contractor vary from month to month and no referral guarantees are made by the County.

County Counsel has approved Exhibits I and II as to use and form.

CONTRACTING PROCESS

Not applicable.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Approval of the recommendations will ensure the continued and effective provision of the FMS and FBRS and maximize DHS' revenue recovery.

Respectfully submitted,

Mitchell H. Katz, M.D.

Director

MHK:adb

Enclosures

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors

EXHIBIT I

H-703466-3

FINANCIAL MANAGEMENT SERVICES AGREEMENT
AMENDMENT NO. 3

THIS AMENDMENT is made and entered into this _____ day of _____, 2013,

by and between COUNTY OF LOS ANGELES (hereinafter "County"),

and SUTHERLAND GLOBAL SERVICES, FORMERLY APOLLO HEALTH STREET, INC. (hereafter "Contractor").

WHEREAS, reference is made to that certain document entitled "FINANCIAL MANAGEMENT SERVICES AGREEMENT", dated September 1, 2008, and further identified as County Agreement No. H-703466 and any Amendments thereto, (all hereafter referred to as "Agreement"); and

WHEREAS, it is the intent of the parties hereto to amend Agreement to provide for the changes set forth herein; and

WHEREAS, Agreement provides that changes to its terms may be made in the form of a written Amendment which is formally approved and executed by the parties.

NOW, THEREFORE, THE PARTIES HERETO AGREE AS FOLLOWS:

1. This Amendment shall become effective on the date of its approval by County's Board of Supervisors, with such date reflected on the top of page 1 of Amendment.

2. Paragraph 1, TERM, shall be deleted in its entirety and replaced by the following:

"1. TERM:

The term of this Agreement shall commence September 1, 2008, and shall continue, unless sooner terminated or canceled, in full force and effect to and including May 31, 2015.

The County shall have the sole option to extend this Agreement term for up to two additional one-year periods, beginning June 1, 2015 through May 31, 2017, with the exercise of such option subject to Board approval in accordance with Paragraph 16, Alteration of Terms.

The County maintains databases that track/monitor Contractor performance history. Information entered into such databases may be used for a variety of purposes, including determining whether the County will exercise a contract term extension option.

The Contractor shall notify DHS when this Agreement is within six (6) months from the expiration of the term as provided for hereinabove. Upon occurrence of this event, the Contractor shall send written notification to the DHS at the address provided in Paragraph 18, Notices, of the Agreement."

3. Paragraph 9, GENERAL INSURANCE REQUIREMENTS, Subparagraph A. (3) shall be deleted in its entirety and replaced by the following:

"(3). Cancellation of or Changes in Insurance

Contractor shall provide County with, or Contractor's insurance policies shall contain a provision that County shall receive, written notice of cancellation or any change in Required Insurance, including insurer, limits of coverage, term of coverage or policy period. The written notice shall be provided to County at least ten (10) days in advance of cancellation for non-payment of premium and thirty (30) days in advance for any other cancellation or policy change. Failure to provide written notice of cancellation or any change in Required Insurance may constitute a material breach of the Contract, in the sole discretion of the County, upon which the County may suspend or terminate this Contract."

4. Paragraph 9, GENERAL INSURANCE REQUIREMENTS, Subparagraph C, Failure to Maintain Coverage, is deleted in its entirety and replaced by the following:

"C. Failure to Maintain Insurance

Contractor's failure to maintain or to provide acceptable evidence that it maintains the Required Insurance shall constitute a material breach of the Contract, upon which County immediately may withhold payments due to Contractor, and/or suspend or terminate this Contract. County, at its sole discretion, may obtain damages from Contractor resulting from said breach. Alternatively, the County may purchase the Required Insurance, and without further notice to Contractor, deduct the premium cost from sums due to Contractor or pursue Contractor reimbursement."

5. Paragraph 19, CONTRACTOR'S WARRANTY OF COMPLIANCE WITH COUNTY'S DEFAULTED PROPERTY TAX REDUCTION PROGRAM, shall be added to the Agreement and incorporated thereto as follows:

"19. CONTRACTOR'S WARRANTY OF COMPLIANCE WITH COUNTY'S DEFAULTED PROPERTY TAX REDUCTION PROGRAM:

19.1 Contractor acknowledges that County has established a goal of ensuring that all individuals and businesses that benefit financially from County through contract are current in paying their property tax obligations (secured and unsecured roll) in order to mitigate the economic burden otherwise imposed upon County and its taxpayers.

19.2 Unless Contractor qualifies for an exemption or exclusion, Contractor warrants and certifies that to the best of its knowledge it is now in compliance, and during the term of this contract will maintain compliance, with Los Angeles Code Chapter 2.206."

6. Paragraph 20, TERMINATION FOR BREACH OF WARRANTY TO MAINTAIN COMPLIANCE WITH COUNTY'S DEFAULTED PROPERTY TAX REDUCTION PROGRAM, shall be added to the Agreement and incorporated thereto as follows:

"20. TERMINATION FOR BREACH OF WARRANTY TO MAINTAIN COMPLIANCE WITH COUNTY'S DEFAULTED PROPERTY TAX REDUCTION PROGRAM:

Failure of Contractor to maintain compliance with the requirements set forth in Paragraph 19 - Contractor's Warranty of Compliance with County's Defaulted Property Tax Reduction Program shall constitute default under this Agreement. Without limiting the rights and remedies available to County under any other provision of this Agreement, failure of Contractor to cure such default within 10 days of notice shall be grounds upon which County may terminate this Agreement and/or pursue debarment of Contractor, pursuant to County Code Chapter 2.206."

7. Exhibit A, STATEMENT OF WORK, shall be replaced in its entirety by Exhibit A-1, Statement of Work and its Attachments thereto, dated May 2013, attached hereto and incorporated herein by reference.

8. Except for the changes set forth hereinabove, Agreement shall not be changed in any respect by this Amendment.

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IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Amendment to be executed by the County's Director of Health Services and Contractor has caused this Amendment to be executed in its behalf by its duly authorized officer, the day, month and year first above written.

COUNTY OF LOS ANGELES

By _____
Mitchell H. Katz, M.D.
Director of Health Services

CONTRACTOR

SUTHERLAND GLOBAL SERVICES

By _____
Signature

_____
Printed Name

_____
Title

APPROVED AS TO FORM
BY THE OFFICE OF THE
COUNTY COUNSEL

EXHIBIT A-1

STATEMENT OF WORK
SUTHERLAND GLOBAL SERVICES
FINANCIAL MANAGEMENT SERVICES

1.0 DEFINITIONS - The terms used throughout this Agreement and in this STATEMENT OF WORK, unless otherwise stated shall mean the following:

1.1 Accepted Account: An Accepted Account is a Referred Account that has been referred to and accepted by Contractor for processing in accordance with the provisions of this Agreement.

1.2 Approved Account: An Approved Account is an Accepted Account that Contractor has requested and received authorization from the referring facility to provide services in accordance with the provisions of this Agreement.

1.3 Confidential Information: All information, tangible or intangible, in whatever form or medium provided or obtained by a party or its representative, directly or indirectly, whether orally or in documents, through and by observation or otherwise, including any developed or learned information by an employee during the course of employment.

1.4 Document or Documentation: Any form or medium provided, including, but not limited to, writings, drawings, graphs, charts, photographs, phonographic records, tape recordings, discs and data compilations in any form recorded or stored from which information can be obtained and/or translated.

1.5 Facility(ies): A County of Los Angeles – Department of Health Services, or Department of Public Health facility that provides health care services.

1.6 Facility Project Monitor: County staff responsible for overseeing the day-to-day administration of this Agreement.

1.7 Other Third-Party Payer: Other Third-Party Payer is a payer source, other than Medi-Cal, Medicare, commercial insurance, Health Care Plan, , for an account, including but not limited to, certain government payers (e.g.,

Genetically Handicapped Person Program ("GHPP"), Child Health and Disability Prevention ("CHDP"), Family Planning, Access, Care and Treatment Program ("FPACT"), Children Medical Services ("CMS"), Cancer Detection Program, etc.).

1.8 Referred Account: A Referred Account is an account that has been forwarded to Contractor by a Facility, in accordance with the provisions of this Agreement and as further identified in this Exhibit A-1 - Statement of Work, for Contractor's assessment and acceptance or rejection.

2.0 SCOPE OF WORK

2.1 Contractor shall provide one or more of the following Financial Management Services of the Contractor after the efforts of the County have been exhausted: 1) Electronic Data Interchange and Clearinghouse Services, 2) Financial Billing and Follow-up Services, 3) Third-Party Resource Identification and Recovery Services, 4) Cost Report Recovery Services, and 5) Underpaid Account Identification and Billing Services, as further described in Paragraph 3.0 - Specific Work Requirements herein. Each service above has various specific requirements which must be performed by Contractor, as detailed in Paragraph 3.0, Specific Work Requirements, herein, to satisfy the County's protocols, payer requirements, and governmental regulations.

2.2 Director may refer the following types of accounts within the categories listed above to Contractor: (1) self-pay accounts determined by the County to have partially or fully unpaid balances; (2) non-self-pay accounts, whether billed or unbilled as having third-party coverage (e.g., Medi-Cal, Medicare, health care plan and commercial insurance, etc.), (3) non-self-pay accounts rejected for payment or otherwise not paid; (4) and/or other types of accounts from different automated systems than herein specified. Notwithstanding the above, Director reserves the right to discontinue any assigned service(s), or recall specific accounts or restrict specific accounts or account types from referral to Contractor. If an account is recalled, Contractor shall terminate services immediately and

return the account and all accompanying account documentation to County within five (5) business days of notice.

2.3 In performing these services, Contractor shall readily accept County's patient financial, admission, eligibility, and other data in various formats (electronic media, magnetic tape, hard copies, and other formats that become available) as determined by the Director. The County Facilities utilize an all-inclusive charge; however, Contractor may be required to perform itemized billings when required by applicable law or payer requirements. All claims processed by Contractor shall comply with the Office of Inspector General (OIG) Program Guidance, State, Federal, HIPAA/HITECH Transaction Code Set (TCS) requirements.

2.4 Contractor shall maintain a comprehensive data warehouse of all accounts, claims, transactions, etc. The database shall be cumulative and contain all accounts processed by Contractor as well as data provided by County and obtained by vendor in performing these services. Upon request by the Director, Contractor shall provide management reports, at no cost to County, as well as customized reports or a system providing County with the ability to generate Ad Hoc reports in a timeframe agreed upon by Director and Contractor.

2.5 Contractor shall provide complete detailed written documentation of the systems, methods, and procedures employed in identification of claims (e.g., eligibility, under paid claims, etc.), claims billing, collection, account posting, and denial follow-up activities. Such documentation exclusive of software shall be provided upon expiration of the term of this Agreement, should County so notify Contractor.

2.6. Comprehensive Audit Trail and Appeal Support: Contractor shall maintain a comprehensive written audit trail and provide audit and appeal support to County, including but not limited to, responding to Auditor requests for documentation and information, packaging information according to Auditor requirements, and interfacing with the Auditors during document review. Contractor shall make available all audit supporting documentation in format and frequency as requested by the Auditor.

2.7 Additional Services: Contractor shall provide ongoing consultant and support services, at no cost to County, including recommendations relating to the future maintenance and updating of the systems, methods and procedures employed by Contractor. Contractor shall also provide recommendations as to how County billings and collections performance might be improved, and support services required to continue provision of those services to be performed by Contractor under this Agreement, at a comparable level of automation/efficiency, during any planned future financial accounting, patient registration, or any other Facility system procured by County and during any other system conversions or augmentations.

3.0 SPECIFIC WORK REQUIREMENTS

The following indicates the areas of services assigned to Contractor, subsidiaries, or subcontractors, as applicable. Contractor may be requested to perform the services below at individual or all Facilities, including but not limited to, Facilities listed in Attachment A - Listing of Facilities. However, the Director, or his designee, may, at any time during the term of this Agreement, add or delete services or Facilities in Attachment A, Facilities List. Contractor shall process all claims timely and in compliance with applicable law and payer requirements. If Contractor fails to process claims timely or default on other contract terms that resulted in lost revenue for the County, County shall have the right to recoup such revenues from future payments to Contractor, or through other means as determined appropriate by County. In performing these services, Contractor shall readily accept County's patient financial, admission, eligibility, and other data in various formats as determined by Facilities (e.g. HL7 data or other formats that become available). Contractor shall provide:

1. Electronic Data Interchange and Clearinghouse Services (EDICS);
2. Financial Billing and Follow-up Services (FBFS);
3. Third Party Resource and Identification and Recovery Services (TPRIRS);
4. Cost Report Recovery Services (CRRS),
5. Underpaid Accounts Identification and Billing services. (UAIBS)

3.1 ELECTRONIC DATA INTERCHANGE AND CLEARINGHOUSE SERVICES (EDICS): Contractor shall provide EDICS to Facilities, including maintaining a comprehensive data warehouse and revenue cycle management (e.g. eligibility verification, electronic remittance, claim status reports, rejection analysis, etc.), as directed by the County. In performing EDICS, Contractor shall:

3.1.1 Submit HIPAA/HITECH compliant Health Care Claim (837) transactions to Medi-Cal, Medicare and other third-party payers or its designated fiscal Intermediary. Data transmission shall utilize HIPAA/HITECH compliant transactions and code sets where such standards exist. Contractor shall enable Facilities to electronically transmit claims on at least a weekly basis or at other frequency requested. Contractor shall have the ability to receive Remittance Advices (835 transaction), Eligibility (271 transaction), and Claim Status (277 transaction) should those services be required. In submitting HIPAA/HITECH compliant Health Care Claim (837) transactions, the Contractor shall:

3.1.1.1 Incorporate detailed edits to identify potential errors, including but not limited to, duplicate claims, provider ID requirements, claim accuracy and coding verification and enable County personnel to make on-line corrections to claims. In addition, Contractor shall provide mechanisms to ensure follow-up notices/reports are provided on unpaid claims.

3.1.1.2 Integrate electronic claims with hardcopy document submissions (i.e. medical records, authorizations, etc.) where appropriate or required by the payer(s) or its fiscal intermediary.

3.1.1.3 Provide County with real time interactive web-portal capability for direct data entry and editing, electronic claims tracking, file uploading, claim payment status (276/277 transaction)

and verification, 270/271 eligibility verification transaction, transaction logs and record history, and payer messaging.

3.1.1.4 Provide comprehensive billing details and summaries of all claims processed through Contractor's system including reports (i.e. aging report, average days to bill/collect, bench mark reports, etc.) for auditing or other management purposes.

3.1.1.5 Post the payments, adjustments, transfers, and billing information in compliance with HIPAA/HITECH TCS requirements (e.g., HIPAA/HITECH 5010 compliant 835 transactions, etc.) to all applicable Facility's accounts receivable systems within two (2) business days if requested by the County. Contractor's failure to post this information within (2) business days will result in fines/assessments as referenced herein in Attachment B, Performance Requirement Summary.

3.1.1.6 Provide payments, adjustments, transfer charges, and billing information transactions in electronic format.

3.1.1.7 Provide all programming changes for any customized and routine reports or customized claims processing, as requested by the County or as required by payer changes (e.g., State requirements, 5010 health claim format, etc.) at no additional cost.

3.1.1.8 Contractor shall provide a secured system environment for data transfer and exchange. Contractor's system shall include, but not limited to, maintaining a secure portal, login and password security, and user authentication and verification. Contractor shall, at the Director's request, provide secured data transfer into the County's current electronic data capturing system in compliance with the County's specified format (e.g., HL7, etc.).

3.1.1.9 Provide technical support services during implementation and operations maintenance at no additional cost.

3.1.1.10 Provide training sessions to County staff at Facilities, as may be requested by the Facility. The subject matter shall include, but not be limited to, new or updated information concerning:

- Medi-Cal billing procedures.
- Medicare billing procedures.
- Commercial insurance billing procedures.
- Other Third-Party Payer billing procedures.
- Utilization of the reports generated.

3.1.2 Perform claims follow-up/tracking services including but not limited to generating health care claims status request and response (276/277) transactions and complete Claims Inquiry Forms (CIF) containing the requisite data elements for accounts requiring tracing and/or denial reconsideration, and perform follow-up services including correcting and resubmitting denied claims. Contractor shall be responsible for submitting all CIF within the required time frames in order to obtain reimbursement. In performing claims follow-up/tracking services, Contractor shall:

3.1.2.1 Assist County in processing and/or pursuing accounts through the State Administrative Appeals process for incorrectly paid or unpaid claims which are referred to Contractor by Facilities. Contractor shall initiate the administrative appeal process when Facilities have provided available requested documentation and County staff have submitted two (2) CIFs to the State of California or its fiscal intermediary, and the claims remain incorrectly paid or unpaid.

3.1.2.2 At the Director's request, create and process electronic CIFs for Medi-Cal denials or payments.

3.1.2.3 Provide separate progress reports of administrative appeals and enable on-line account status and inquiry by County staff.

3.1.2.4 At the Director's request, provide written recommendations on resolutions, approaches, or procedures to resolve problems.

3.1.3 Perform claim processing for the County's Substance Abuse Prevention and Control (SAPC) Office: Contractor shall provide Medi-Cal Drug Treatment Claim Processing (MDTCP) and Minor Consent Eligibility Claim Processing (MCECP) services compliant with HIPAA/HITECH Health Care Claim (837) transactions. Contractor shall encrypt Medi-Cal claim data, for certain drug treatment Medi-Cal recipients, prior to submission of such Medi-Cal claims to the State for payment. Contractor shall have the ability to receive State Medi-Cal transaction data, e.g., Remittance Advices, Eligibility Responses, Claims Status, etc. MDTCP and MCECP services shall be provided by Contractor for all Drug Treatment Medi-Cal claims referred to Contractor by SAPC, except as otherwise determined by the County. In performing claim processing, Contractor shall:

3.1.3.1 Receive Medi-Cal drug treatment claims and information for eligibility checking, which is used in part to determine minor consent as well as other health care coverage status, from the SAPC office, at a minimum, on a monthly basis, or more frequently as requested by the Facility.

3.1.3.2 Process such Medi-Cal drug treatment and minor consent claim/eligibility information into HIPAA/HITECH acceptable format, including mapping data elements and data conversion.

3.1.3.3 Electronically forward HIPAA/HITECH acceptable reformatted Medi-Cal claims for drug treatment to the State fiscal intermediary for payment on a monthly basis, but no later than the thirtieth (30th) of the month following the month

that claim information was received from SAPC. Provide back eligibility status within three (3) business days that eligibility information was received from SAPC.

3.1.3.4 Electronically forward claims reformatted into HIPAA/HITECH compliant 270 transaction code sets to the state for Drug Medi-Cal eligibility determination on a monthly basis. Contractor shall provide SAPC a listing of accounts with the corresponding aid codes, which will determine minor consent status, obtained from the State transactions no later than the 21st of each month unless a different time frame is determined by the County.

3.1.3.5 Contractor shall have the ability to receive State Medi-Cal transaction data [Remittance Advices (835 transaction), Eligibility (271 transaction), and Claim Status (277 transaction)], should those services be required of the Contractor.

3.1.3.6 Provide the following automated management reports at the frequencies listed:

1. Claims File Confirmation Report, within three (3) business days of receipt of claim information from SAPC,
2. State Confirmation Report that includes the number of claims received and billed amount, within three (3) business days of State confirmation of claims received by the State,
3. Supplemental Claim Information Report, as needed, and
4. Additional reports, as requested by the Director with concurrence of Contractor.

3.2 Financial Billing and Follow-Up Services (FBFS): Contractor shall provide FBFS as requested by Facilities for referred accounts. The County currently utilizes an all-inclusive charge, however, FBFS may include itemized billing where required by applicable law or payer requirements and encompasses the following third-party programs:

Medicare, Medi-Cal, Health Care Plan and Commercial Insurance (i.e. HMO, HCP, Medi-Cal Linked, etc.) and other third-party payers and may be specific to inpatient accounts or outpatient accounts or both. This includes billing and follow-up services, denial reprocessing, review medical records for appeals, and using automated systems where available and appropriate or as requested by County.

Contractor shall request the necessary information (e.g., approved Treatment Authorization Request (TAR), or patient discharge summaries, etc.) needed to develop valid reimbursement claims directly from the source organization (e.g., Utilization Review, Medical Records, Patient Financial Services, etc.). Contractor will provide personnel to assist in retrieving/photocopying documents as may be requested by the Source Organizations and return all account documentation reviewed in the same condition and sequence in which they were originally received.

Contractor shall, within five (5) business days, bring to the attention of the Facility Patient Accounts Manager/CBO Manager, when the Contractor is having difficulty in obtaining information which prohibits the Contractor from billing or following-up on accounts.

If Contractor cannot obtain the necessary medical records coding from the Facility, the Contractor may elect to utilize its own coding staff or contracted coding vendor that has been approved by County as a subcontractor at Contractor's expense.

Contractor shall provide any one or all of the following services to Facilities as agreed upon between County and Contractor:

3.2.1 Research unbilled Inpatient and/or Outpatient accounts that have been classified as having third-party coverage on the Accounts Receivable (A/R).

3.2.2 Research all unbilled accounts on the A/R systems with discharge or service dates as requested by Facility to verify third-party coverage, except those assigned by County to other contract service providers. Contractor shall verify eligibility or recommend other appropriate disposition of these accounts to Facility staff if no eligibility can be determined or non-matching eligibility.

3.2.3 Employ a claim edit system to review all data from Facility systems to create claims that are compliant with payer regulations and work with Facility staff to resolve all pre-bill edit failures (e.g., missing or incorrect patient demographic and charge information, partial eligibility matches, and missing or incomplete medical record data, etc.). The updated information will be entered directly into the Contractor's billing processes. Contractor shall review medical record/chart as necessary where itemized billing is required (e.g., OB/Peds Billing, etc.).

3.2.4 Generate electronic or hardcopy of claims, including itemized claims where appropriate and necessary, and ensure claims are compliant with Federal, State, and other regulatory requirements and submit claims timely to the appropriate fiscal intermediary or other third-party payers. Contractor shall develop and bill Medicare, Medi-Cal, health care plan and commercial insurance, or other third-party payer, claims that meet the requirements of the applicable fiscal intermediary or third-party payer, in electronic format where possible. Contractor shall generate electronic or hardcopy work queues of claims with invalid eligibility matches and research accounts on payer's on-line eligibility systems or with the Facilities' eligibility systems. If valid eligibility is identified, the information shall be entered directly into the billing system by Contractor. When necessary, Contractor shall review medical records to ensure all mandated codes exist prior to billing. The updated information will be entered directly into the Contractor's billing processes by Contractor staff.

3.2.5 Provide County updated demographic and third-party resources information at the time of billing to include third party updates and third-party payer identification number (e.g., insurance code updates, Medi-Cal ID#, etc.) and provide updates for revised and/or corrected information obtained by vendor in electronic format.

3.2.6 Develop fully and submit, in a timely manner, completed Medi-Cal, Medicare, health care plan and commercial insurance, and/or any other third-party claims/billings, in electronic format where appropriate, to Affiliated Computer Services (ACS) (or a successor fiscal intermediary for Medi-Cal), or Palmetto or National Heritage Insurance Company (or a successor fiscal intermediary for Medicare), or the appropriate Independent Practice Association (IPA) /Participating Physician Group (PPG) or capitated Hospital and/or other third-party payers or fiscal intermediaries.

3.2.7 Follow-up on billed and unpaid accounts according to the third party payer timeline and follow appropriate processes to determine claim status including usage of 276/277 transactions.

3.2.8 Follow-up on denied claims, determine the cause of the denial, correct deficiency, and resubmit claims for payment unless the claim is determined to be uncollectible. When necessary, Contractor shall review medical records of denied or incorrectly paid claims to determine if an appeal is appropriate. If an appeal is appropriate, Contractor shall file the appeal with the appropriate payer (e.g., IPA/PPG, capitated hospital, etc.). Contractor shall document the reasons the account is uncollectible and report to the referring Facility(ies).

1. Respond within three (3) business days, if information is available, to additional information requested (e.g., correspondence, etc.) by Medicare, Medi-Cal, health care plan and commercial insurance, other third-party payer or from applicable fiscal intermediary.

2. Research and resubmit claims billed by Contractor which are suspended or denied by the fiscal intermediary (e.g., complete and return resubmission turnaround documents, Claim Inquiry Forms (CIF), etc.) and provide all follow-up services for denied claims and pursue third-party payments until the account is determined to be uncollectible. Contractor shall document the reasons the account is uncollectible and report to the Facilities.

3.2.9 Pursue full reimbursement for non-contracted commercial insurance accounts identified by the Facility(ies). Contractor shall submit in writing any proposed settlement/account compromise, with amount and reason for compromise, to County for approval prior to acceptance, in accordance with DHS' procedures. Contractor shall negotiate with the third-party payer to ensure that the compromise offer is fair and equitable. Contractor shall submit all compromise offers to County only when it has determined that the offered amount is the best offer that can be negotiated. For this purpose, Contractor shall provide County all information/documentation in three (3) business days. If County personnel are required to attend hearings and/or settlement conferences, Contractor shall notify County at a minimum of fifteen (15) business days in advance of the hearing/conference date.

3.2.10 Establish and Maintain a claim/payment tracking system to identify by account, category, Facility, and in total, amounts billed, collected, pending, denied, paid, and accounts referred back to Facilities). Contractor shall provide aging reports for accounts billed each month or as requested by referring Facility(ies).

3.2.11 Post (HIPAA/HITECH Compliant 835 transaction) the payments, denials, adjustments, and transfers, electronically, to all applicable Facility's A/R systems within two (2) business days. Contractor shall post, on a continuing basis, Medi-Cal, Medicare, health plan and commercial insurance and other third-party remittances and contractual allowances within five (5) business days after

Contractor's receipt of Remittance Advices. Contractor shall provide payment posting detail for accounts that have been billed by Contractor and subsequently paid.

3.2.12 Establish a payment tracking process on the accounts billed by Contractor to identify amounts billed and amount collected and provide an accounts aging report for the accounts billed by Contractor and perform monthly review of all Accepted Accounts that were paid to ensure accounts are appropriately adjudicated.

3.2.13 Research credit balances on Accepted Accounts and billed accounts to ensure payments are correctly recorded. If overpayment is identified, Contractor shall process repayment to the appropriate third party payer(s) within the timeframe specified by the payer. Contractor shall provide monthly reports that identify over-payments and the appropriate actions taken to initiate refunds and/or corrections.

3.2.14 Provide Facilities with a listing of the accounts with amounts determined to be self-pay.

3.2.15 Provide payments, adjustments, transfer charge, and billing information transactions in electronic format.

3.2.16 Provide various management reports (i.e., eligibility identifications, claims billed, collections, remittance advice, denials, and other reports, in formats, content, and frequency).

3.2.17 Compile, as requested by the County, an assessment of Medicare outpatient or other services provided by other hospitals in the Southern California area, using area-specific Medicare outpatient analytical data, to identify areas of actual and/or potential lost revenue and ensure revenue maximization.

3.2.18 Return health care plan and commercial insurance accounts that are unbilled within one hundred fifty (150) calendar days after Contractor initially received the account from County, except as otherwise instructed by the Facility(ies) Contractor shall return all supporting documentation, including but not limited to, eligibility

information, medical records, correspondence and explanation of benefits, etc., to Facilities upon return of the accounts.

3.2.19 Return health care plan and commercial Insurance accounts to the County that have been billed, but are unadjudicated two hundred seventy (270) calendar days after the last billing, except as otherwise instructed by the Facility. Contractor shall return all supporting documentation, including but not limited to, eligibility information, medical records, correspondence and explanation of benefits, etc., to Facility upon return of the accounts.

3.2.20 Follow DHS balance billing guideline for emergency services.

3.2.21 Provide, develop, and maintain a database to accumulate patient data, charge information, billing statistics, payment information, and other data as necessary. Contractor shall allow County's staff to access the database for inquiries, reporting, and as otherwise necessary.

3.2.22 Provide automation of various management reports as specified and defined by applicable Facilities.

3.2.23 Provide County with a quarterly assessment of each Facility's performance. Any concerns and recommendations to improve FBFS shall be included in such report.

3.2.24 Provide assistance to Facilities in submitting HIPAA/HITECH compliance 837 claims for mental health services to Los Angeles County Department of Mental Health (LAC-DMH). Contractor shall:

1 Capture Psychiatric Services account data from Facility (Hard copy encounters are entered into County's Health Information System and provided to Contractor) and Department of Mental Health information system to create a warehouse containing the necessary information to submit valid mental health claims.

2 Obtain hard copy or electronic Utilization Review documents from Facility in order to manually look up (manual look up is performed using any combination of patient demographic information such as Name, Social Security, Date of Birth, etc.)

and open episodes in the Mental Health information system. Contractor shall verify if the patient episode has been established or create a new episode in a timely manner as appropriate.

3. Manual lookup will be performed by Contractor periodically on the Facility UR system in order to obtain the allocation of days (AOD) for inpatient accounts. The AOD will determine the level of visits (acute, administrative or denied days) to be utilized to create the final claims. Contractor shall obtain the discharged date and enter into the Mental Health information system allowing an episode to be closed.
4. Analyze the entire patient file and work with Facilities to reconcile, edit, and locate missing information to build and submit valid claims and maximize recovery. Contractor shall develop a process for accurately matching accounts in order to obtain eligibility information including identifying retroactive eligibility. Accounts with unidentified eligibility will be recycled every month until expiration of the billing time statue.
5 Provide monthly and customized reports, including but not limited to, Mental Health Billing Report and Mental Health Medical Record Abstract (MRA) Missing Information.

3.3 Third-Party Resource Identification and Recovery Services (TPRIRS): After DHS's best efforts have been exhausted; DHS shall refer to Contractor accounts for third party coverage identification and claim processing services. In performing TPRIRS, Contractor shall:

3.3.1 Request the necessary information (e.g., approved TARS, or patient discharge summaries, etc.) needed to develop valid reimbursement claims directly from the facility(ies) (e.g., Utilization Review, Medical Records, Patient Financial Services, etc.) including comprehensive chart review to access coding, perfection of claims, etc. necessary for itemized billing. Contractor shall provide personnel to assist in retrieving/photocopying documents.

1. Contractor shall notify the Patient Accounts Manager/CBO Manager within three (5) business days, when the Contractor is having difficulty in obtaining information which prohibits the Contractor from billing or following-up on accepted accounts.
2. If Contractor cannot obtain the necessary medical records coding from the Facility, the Contractor may elect to utilize its own coding staff or contracted coding vendor if already approved by County as a subcontractor at Contractor's expense.

3.3.2 Utilize demographic, charge, and remittance data to construct a file of un-liquidated accounts that are unidentified by the Facility as having third-party coverage. The Contractor shall then apply remittance data to this file of unidentified accounts to identify and eliminate all previously liquidated services.

3.3.3 Provide all Facilities receiving TPRIRS with a monthly listing of accounts that are eligible for third-party reimbursement for which Contractor has conducted a review to ensure that no claim by County or another contractor has been paid or is pending adjudication by the third-party payer or its fiscal intermediary. The Facilities will delete accounts from this listing that are currently being pursued by the County or another contractor. The Contractor shall then pursue reimbursement only for accounts which have been approved by the Facility.

3.3.4 Provide all Facilities receiving TPRIRS with a monthly listing (electronic or paper) of Approved Accounts that are not being pursued within seven (7) calendar days of identifying third-party eligibility where payment was not received, with an explanation of the reason(s) TPRIRS efforts will not be pursued. If Contractor needs additional time to determine acceptance/rejection of said account(s), additional time may be requested by Contractor and may be granted by the County, not to exceed one hundred and

twenty (120) calendar days after Contractor initially received the Referred Account from County.

3.3.5 Employ a claim edit system to review all data from Facility systems to create a claim that is compliant with payer regulations and work with Facility staff to resolve all pre-bill edit failures (e.g., missing or incorrect patient demographic and charge information, partial eligibility matches, and missing or incomplete medical record data). The updated information will be entered directly into the Contractor's billing processes.

3.3.6 Generate electronic or hardcopy of claims, including itemized claims when necessary, and ensure claims are compliant with Federal, State, and other regulatory requirements and submit claims timely to the appropriate fiscal intermediary and other third-party payers. Contractor shall develop and bill Medicare, Medi-Cal, health care plan and commercial insurance, or other third-party payer claims that meet the requirements of the applicable fiscal intermediary or third-party payer, preferably in electronic format where applicable. Contractor shall generate electronic or hardcopy work queues of claims with invalid eligibility matches and research accounts on payer's on-line eligibility systems or with the Facilities' eligibility systems. If valid eligibility is identified, the information will be entered directly into the Contractor's billing system. When necessary, Contractor shall review medical records to ensure all mandated codes exist prior to billing. The updated information will be entered directly into the Contractor's billing processes by Contractor staff.

3.3.7 Provide updated demographic and third-party resources information at the time of billing to include third-party updates and third-party identification number (e.g., insurance code updates, Medi-Cal ID#, etc.) in electronic format.

3.3.8 Develop fully and submit completed Medi-Cal, Medicare, health care plan and commercial insurance, and/or any other third-party

claims/billings, preferably electronically to Affiliated Computer Services (ACS) (or a successor fiscal intermediary for Medi-Cal), or Palmetto or National Heritage Insurance Company (or a successor fiscal intermediary for Medicare), or the appropriate Independent Practice Association (IPA) /Participating Physician Group (PPG) or capitated Hospital and/or other third-party payers or fiscal intermediaries.

3.3.9 Follow-up on billed and unpaid accounts according to the third party payer timeline and follow appropriate processes to determine claim status including usage of 276/277 transactions.

3.3.10 Follow-up on denied claims, determine the cause of the denial, correct deficiency, and resubmit claims for payment unless the claim is determined to be uncollectible. When necessary, Contractor shall review medical records of denied or incorrectly paid claims to determine if an appeal is appropriate. If an appeal is appropriate, Contractor shall file the appeal with the appropriate payer (e.g., IPA/PPG, capitated hospital, etc.). Contractor shall document the reasons the account is uncollectible and report to the referring Facility(ies).

1. Respond within three (3) business days, if information is available, to additional information requested (e.g., correspondence, etc.) by Medicare, Medi-Cal, health care plan and commercial insurance, other third-party payer or from applicable fiscal intermediary.
2. Research and resubmit claims billed by Contractor which are suspended or denied by the fiscal intermediary (e.g., complete and return resubmission turnaround documents, CIF, etc.) and provide all follow-up services for denied claims and pursue third-party payments until the account is determined to be uncollectible. Contractor shall document the reasons the account is uncollectible and report to the Facilities.

3.3.11 Pursue full reimbursement for commercial insurance account. Contractor shall submit in writing any proposed settlement/account compromise, with amount and reason for compromise, to County for approval prior to acceptance in accordance with procedures as follows: Contractor shall negotiate with the third party to ensure that the settlement amount allocated to the County is fair and equitable. Contractor shall submit such compromise offers to County only when they have determined that the offered amount is the best offer that can be negotiated. For this purpose, Contractor shall provide County all information/ documentation in three (3) business days. If County personnel are required to attend hearings and/or settlement conferences, Contractor shall notify County at a minimum of fifteen (15) business days in advance of the hearing/conference date.

3.3.12 Establish and maintain a claim/payment tracking system to identify by account, category, Facility, and in total, amounts billed, collected, pending, denied, paid, and accounts referred back to Facilities or primary contractor(s). Contractor shall provide aging reports for accounts billed each month or as requested by referring Facility(ies).

3.3.13 Post (HIPAA/HITECH Compliant 835 transaction) the payments, adjustments, and transfers, preferably electronically, to all applicable Facility's A/R systems within two (2) business days. Contractor shall post on a continuing basis, Medi-Cal, Medicare and other third-party remittances and contractual allowances within five (5) business days after Contractor's receipt of Remittance Advices. Contractor shall provide payment posting detail for accounts that have been billed by Contractor and subsequently paid.

3.3.14 Establish a payment tracking process on the accounts billed by Contractor to identify amounts billed and amount collected and provide an accounts aging report for the accounts billed by

Contractor and perform monthly review of all Accepted Accounts that were paid to ensure accounts are appropriately adjudicated.

3.3.15 Research credit balances on Accepted and billed accounts to ensure payments are correctly recorded. If overpayment is identified, Contractor shall process repayment to the appropriate third party payer(s) within the timeframe specified by the payer. Contractor shall provide monthly reports that identify over-payments and the appropriate actions taken to initiate refunds and/or corrections.

3.3.16 Provide Facilities with a listing of the accounts with amounts determined to be self-pay.

3.3.17 Provide payments, adjustments, transfer charge, and billing information transactions in electronic format.

3.3.18 Provide various management reports (i.e., eligibility identifications, claims billed, collections, remittance advice, denials, and other reports, in formats, content, and frequency).

3.3.19 Follow DHS balance billing guideline for emergency services.

3.3.20 Provide, develop, and maintain a database to accumulate patient data, charge information, billing statistics, payment information, and other data as necessary. Contractor shall allow County's staff to access the database for inquiries, reporting, and as otherwise necessary.

3.3.21 Provide automation of various management reports as specified and defined by applicable Facilities.

3.3.22 Provide County with a quarterly assessment of each Facility's performance. Any concerns and recommendations to improve TPRIRS shall be included in such report.

3.4 Cost Report Recovery Services (CRRS): At the County's direction Contractor shall provide CRRS to Facilities, including but not limited to:

1. Medicare Bad Debt Recovery Services;
2. Disproportionate Share Recovery Services; and
3. Indirect Medical Education Recovery Services.

3.4.1 Medicare Bad Debt Recovery Services (MBDRS): Contractor shall maximize Medicare Bad Debt reimbursement costs by substantiating Medicare Bad Debts information and provide federally acceptable Medicare claims. Contractor shall develop an integrated database to identify and process Medicare billing and collection information, i.e., the amount of bad debts associated with co-insurance and deductibles, and produce auditable Medicare Bad Debt Reports by Facility. Contractor shall:

3.4.1.1 Prepare a Medicare Bad Debt Report for each Fiscal Year (FY) as requested by Director. Each report shall include a listing, by Facility of Medicare Bad Debt accounts and account activity.

3.4.1.2 Create and compile a warehouse of electronic Medicare payment data (Remittance) for County inpatient and outpatient accounts. Contractor shall match the Remittance data to County Facility Statistical Master file.

3.4.1.3 Obtain information from the County for Medicare accounts deemed uncollectible.

3.4.1.4 Analyze Medicare account(s) information to identify any coinsurance and deductible payments.

3.4.1.5 Analyze collection activities/data from Patient Accounts system and any ancillary files (received from the County and/or other County contractors) to a) identify collection activity, and b) examine write-off transaction and write-off timing.

3.4.1.6 Identify potentially qualifying accounts by various codes, indicating their characteristics as they pertain to Medicare Bad Debt claiming.

3.4.1.7 Create a listing of Medicare Bad Debt accounts by Facility for all accounts that qualify for Medicare Bad Debt claiming. Each listing shall include patient demographics, Medicare Health Insurance Claims (HIC) number,

coinsurance amount, deductible amount, payments, write-offs, and Medicare Bad Debt allowable amount.

3.4.1.8 Provide this Medicare Bad Debt Report (by Facility) to the County within sixty (60) days following the end of each fiscal year (June 30), or as requested by the County.

3.4.2 Disproportionate Share Recovery Services (DSRS): As requested by the County and with Contractor's concurrence, Contractor shall provide Medicare DSRS to Maximize County's Medicare Disproportionate Share Hospital (DSH) reimbursement in compliance with Medicare regulations. Contractor shall develop an integrated database to identify additional eligibility inpatient days, prepare necessary documentation, and secure acceptance from the Medicare fiscal intermediary for Medicare DSH claiming. Further, Contractor shall produce reports and compile detailed listing and claims for filing with Medicare, as required or as requested by County with concurrence of Contractor to provide claiming for eligible inpatient days. DSRS shall be provided by Contractor for all inpatient hospital Facilities, except as otherwise determined by the County. Contractor shall prepare Facility-specific listings and reports of eligible patient days and Medicare DSRS claims for dates of service as requested by County. Contractor shall:

3.4.2.1 Create and compile a warehouse of electronic inpatient account information. Contractor shall reformat account information provided by County to standard Medicare DSH record types, creating records for all accounts.

3.4.2.2 Identify a universe of the potential Medicare DSH population by analyzing the compiled inpatient account information and segregating inpatient account information into potential Medicare DSH groups for each fiscal year as determined by County. To identify the universe of the potential Medicare DSH population, Contractor shall:

1. Match inpatient account records against Medi-Cal remittance data.
2. Match inpatient account records against eligible 1115 waiver days
3. Match inpatient account records against uninsured accounts
4. Perform self-pay conversion processing to identify potential incremental Medi-Cal and Medi-Cal Managed Care days.
5. Select accounts with patient days for dates of service for each fiscal year as requested by Director, and categorize accounts by Medicare DSH type.
6. Accurately match inpatient account records to Medi-Cal eligibility dates.
7. Review days already claimed and paid by the fiscal intermediary and deduct these days from the Medicare DSH population.
8. Independently evaluate accuracy of the Medicare-assigned Supplemental Security Income (SSI) ratio for each fiscal year as determined by County, as follows:
   - Match the federal Centers for Medicare and Medicaid Services SSI file to inpatient account records;
   - Identify "dual-eligible" inpatient account records found on County system but not found on SSI file;
   - Research inconsistencies for non-matching instances to ascertain Medi-Cal coverage type, if any; and
   - Create a report of "dual eligible" inpatient account records not included in SSI ratio.

3.4.2.3 Prepare listings and reports by Facility as follows:

1. Medicare DSH exclusion report.
2. Payment status segregation report.
3. Reconciliation report of paid days to DSH listing, as necessary.
4. Plan code and service type summary report listing.
5. Medicare detail report (for filing with Medicare).

3.4.2.4 Additional Runs – Contractor shall perform up to three (3) additional runs after its initial Medicare detail report for filing with Medicare to potentially increase the Medi-Cal eligible days. The timing of the runs will be determined by the County. Contractor will be paid a fee based on Paragraph 10, Provision of Payment, herein, depending upon the issuance of the Revised Notice of Program Reimbursement (RNPR) reflecting these additional Medi-Cal eligible days.

3.4.2.5 For fiscal years where a final Medicare Cost Report settlement has been rendered, prepare claims for reopening or appeal, as appropriate and as determined by the County.

3.4.2.6 For fiscal years where a final Medicare Cost Report is pending, prepare claims for supplementing the pending Report.

3.4.2.7 Provide Medicare DSRS claims with dates of service to County upon request, where a final Medicare Cost Report settlement has been rendered or pending. Contractor shall provide to County Medicare DSRS claims with dates of service as determined by the County, within two (2) years following the end of the fiscal year (June 30).

3.4.3 Indirect Medical Education Recovery Services (IMERS): At the County's discretion and with Contractor's concurrence, Contractor shall provide IMERS to Maximize County's Indirect Medical

Education (IME) reimbursement in compliance with Medicare policies and regulations. Contractor shall:

3.4.3.1 Review the current impact of existing IME reimbursement and analyze the recovery rate. Develop, with Facility's approval, a processing flow to optimize IME reimbursement at Facilities.

3.4.3.2 Implement with Facility's approval, methodology for production of shadow billing, follow-up and collection.

3.4.3.3 Provide appropriate periodic reporting to County to document results.

3.5 Underpaid Account Identification and Billing Services (UAIBS): Contractor shall identify underpaid accounts after these accounts have been closed by County or its primary contractor(s): Assign accounts will be based on protocol established and agreed upon between County and Contractor. Contractor shall:

3.5.1 Utilize demographic, charge, and payment data, Contractor shall identify and construct a file of underpaid accounts as having third-party coverage.

3.5.2 Apply appropriate fee schedules to determine if the claims were paid accordingly or if additional payment can be received due to errors or insufficient information and eliminate all accounts which were reimbursed appropriately.

3.5.3 Provide all Facilities receiving UAIBS with a monthly listing of accounts that are found to have been underpaid by the third party payer (e.g. workers compensation, commercial insurance, etc.), for which Contractor has conducted a review sufficient to ensure that no claim by County or its primary contractor exists. Facilities will delete accounts from the listing that are currently being pursued by the County or its primary contractor. Contractor shall then pursue reimbursement only for accounts remaining on the listing.

3.5.4 Provide all Facilities receiving UAIBS with a monthly listing (electronic or paper) of Approved Accounts which will not be

pursued and no additional reimbursement was received, with an explanation of the reason(s) further efforts will not be pursued.

3.5.5 Employ a claim edit system to review all data from Facility systems to create a revised claim that is compliant with payer regulations and work with Facility staff to resolve all pre-bill edit failures (e.g., missing or incorrect patient demographic and charge information, etc.).

3.5.6 Provide County updated demographic and third-party resources information at the time of billing to include insurance information updates and third-party identification number (Carrier code updates, insurance billed, etc.) in electronic format.

3.5.7 Fully develop and submit, unless otherwise instructed by County, completed third-party revised claims/billings, preferably electronically, to the third-party payers or fiscal intermediaries.

3.5.8 Follow-up on denied claims, determine the cause of the denial, correct deficiency, and resubmit claims for payment unless and until the claim is determined to be uncollectible. Contractor shall document the reasons the account is uncollectible and report to the applicable Facilities.

3.5.9 Maintain a claim/payment tracking system to identify by account, category, Facility, and in total, amounts billed, collected, pending, denied, paid, and accounts referred back to Facilities or primary contractor(s). Contractor shall provide aging reports for accounts billed each month or as requested by applicable Facilities.

3.5.10 Post the payments, adjustments, and transfers to all applicable Facility's accounts receivable systems within two (2) business days, as may be requested. Contractor's failure to post this information timely will result in fines/assessments as referenced in Attachment B, Performance Requirements Summary.

3.5.11 Provide (in electronic format) payments and adjustment transactions.

3.5.12 Provide various management reports regarding under paid claims accepted, accepted claims not pursued and reason for not pursuing, claim billed, collections, remittance advice, denials, and other reports, in formats, content, and frequency to be determined by the County.

4.0 REQUIRED REPORTS

From time to time, the Director, or his designee, may request additional reports or one time only reports created from Contractor's existing data fields. Contractor shall make such reports available to County within one (1) week from Director's request or as otherwise agreed to by County and Contractor. All other routine management reports must be provided timely per established due date.

5.0 ADDITION/DELETION OF FACILITIES, SPECIFIC TASKS AND/OR WORK HOURS

Contractor shall provide one or more services listed in Scope of Work, Paragraph 2.1, as requested by each Facility listed in Attachment A, Facilities List.

However services may change as a result of deletion or addition of new Facility(ies), future consolidation of existing Facilities or as changes are required by law. Therefore, Contractor shall accept assignments or deletions of Facility (ies) and/or services deemed by the County to be in its best interest.

6.0 QUALITY CONTROL

The Contractor shall establish and maintain a written Quality Control Plan to ensure that the requirements of the Agreement are met. The Quality Control Plan may be in a chart format. An updated copy must be provided to the County's Project Director ten (10) business days after the Agreement start date and within ten (10) business days when changes occur during the term of the Agreement. The plan shall discuss, but not be limited to, the following:

1) The Contractor's quality control or monitoring system covering each individual item listed in Paragraph 9, Performance Requirements Summary, herein, must specify the activities to be monitored on either a scheduled or unscheduled basis, how often monitoring will be accomplished, and the title of the individual(s) who will perform the monitoring.

2) The methods for identifying and preventing deficiencies in the quality of service performed before the level of performance becomes unacceptable and not in compliance with the Agreement.

3) The methods for documenting the monitoring results and, if necessary, the corrective actions taken.

4) The method for assuring that confidentiality of patient information is maintained while in the care of Contractor.

5) The method for assuring new Contractor employees will sign an Acknowledgement of Confidentiality Agreement (Attachment B-1) prior to starting employment, and will understand and abide by its terms upon starting employment.

On an ongoing basis the Contractor's performance will be compared to the Agreement standards and Acceptable Quality Levels (AQLs) as referenced in Attachment B, Performance Requirement Summary. DHS may use a variety of inspection methods to evaluate the Contractor's performance, including but not limited to: random sampling; one hundred percent inspection of its output items on a periodic basis (daily, weekly, monthly, quarterly, semiannually or annually) as determined necessary to assure a sufficient evaluation of the Contractor's performance; review of reports and files; complaints from DHS; site visits; and patient complaints.

7.0 QUALITY ASSURANCE PLAN: The County will evaluate the Contractor's performance under this Agreement using the quality assurance procedures as defined herein in Paragraph 9.0, Performance Requirements Summary.

7.1 Periodic Meetings

Contractor is required to attend a scheduled monthly meeting, or as otherwise determined by Director. Failure to attend will cause an assessment of one hundred dollars ($100.00).

7.2 Contract Discrepancy Report

Verbal notification of a Contract discrepancy will be made to the Contractor as soon as possible whenever a Contract discrepancy is identified. The problem shall be resolved within a time period mutually agreed upon by the County and Contractor. The Facility Project Monitor will determine whether

a formal Contract Discrepancy Report shall be issued. Upon receipt of this document, the Contractor is required to respond in writing to the Facility Project Monitor within five (5) business days, with a plan for correction of all deficiencies identified in the Contract Discrepancy Report.

7.3 County Observations

In addition to departmental contracting staff, other County personnel may observe performance, activities, and review documents relevant to this Agreement at any time during normal business hours. However, these personnel may not unreasonably interfere with the Contractor's performance.

8.0 RESPONSIBILITIES

COUNTY

8.2. County Personnel and Records:

8.2.1 County does not anticipate assigning any County employees to assist Contractor on a full-time basis regarding services to be provided by Contractor pursuant to this Agreement. However, County personnel will be made available to Contractor, if deemed necessary by the County, to provide input and assistance in order to answer questions and provide necessary liaison between Contractor and County departments.

8.2.2 The various operational/administrative records and statistics of County's health operations shall be provided to Contractor for review and evaluation whenever deemed appropriate and feasible by County, and as may be allowed by applicable law.

8.3 Access to Information:

8.3.1 In order for Contractor to perform the services described in this Statement of Work, County shall cooperate with Contractor to allow access to such financial, medical and other operating data as may be allowed by Director and applicable law, including among other things the following:

8.3.1.1 Patient demographic, admission, and registration data from the respective Facility admission and registration system files, as available in format determined by Director.

8.3.1.2 Inpatient and ambulatory billing forms and billing folders for Medi-Cal, Medicare, and commercial insurance.

8.3.1.3 Affinity or other County patient accounting and accounts receivable information in format and timeframe determined by Director.

8.3.1.4 Medicare, Medi-Cal, and other third-party payer Remittance Files, Contractor shall reimburse County for the County's cost to reproduce these files for Contractor's use.

8.3.1.5 County patient medical records, for purposes of determining and verifying dates of patient service and other diagnosis information required for successful reimbursement.

8.3.1.6 File layouts, if necessary, for each of the files.

8.3.1.7 At Director's discretion, any additional files, documents, system access, or information deemed appropriate to Facilitate performance of the services described in Statement of Work.

CONTRACTOR

8.1.1 Contractor shall work independently on designated assignments in accordance with this Statement of Work.

8.1.2 Notwithstanding any representation by County regarding the participation of County personnel in any phase of this project, Contractor assumes sole responsibility for the timely accomplishment of all activities assigned in this Agreement.

8.1.3 Contractor(s) shall furnish all labor, materials, supplies, personnel, equipment, and administrative support necessary to perform the services under this Agreement. Contractor shall use materials and

equipment that are safe for the environment and safe for use by the employee. At the County's sole discretion, the County may assign space, chairs, desks, and office equipment (e.g., telephones, fax machines, photocopying equipment, etc.) on a non-exclusive basis, for work area and related use by the Contractor. In the event the County assigns space and office equipment to the Contractor, Contractor shall use the space and office equipment only for the purpose of the performance of services hereunder. The Contractor is prohibited from use of such space and office equipment for the purposes other than for the performance of this Agreement.

8.4 Project Manager:

The Contractor's Project Manager shall be responsible for the Contractor's day-to-day activities as related to this Agreement and shall coordinate with Facility's Project Manager and Facility's Project Monitor on a regular basis.

8.4.1 Contractor shall provide a full-time Project Manager or designated alternate. County must have access to the Project Manager during all hours, 365 days per year. Contractor shall provide a telephone number where the Project Manager may be reached on a twenty-four (24) hour per day basis.

8.4.2 Project Manager shall act as a central point of contact with the County.

8.4.3 Project Manager/designee shall have full authority to act for Contractor on all matters relating to the daily operation of the Agreement. Project Manager/designee shall be able to effectively communicate, in English, both orally and in writing.

8.4.4 Contractor shall respond to all County inquiries, including but not limited to, status and follow-up, telephonic, e-mail or facsimile inquiry, within twenty-four (24) hours of initial inquiry. Failure to respond in a timely manner will result in fines/assessments as referenced in Attachment B, Performance Requirements Summary.

8.5 Personnel:

8.5.1 Contractor shall assign a sufficient number of employees to perform the required work.

8.5.2 Contractor's staff shall be required to undergo background checks as set forth in Paragraph 1, Administration of Agreement, subparagraph D, Background & Security Investigations, of the Agreement.

8.6 Intentionally Omitted

8.7 Training:

Contractor shall provide training programs for all new employees and continuing in-service training for all employees to perform the required work of this Agreement. Contractor's staff must be adequately trained and adhere to County Facility's information security policies and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH) regulations in protecting the privacy and confidentiality of patient information at all times. Failure to comply with these requirements may result in fines/penalties, contract termination and/or legal prosecution.

8.8 Contractor's Office:

Contractor shall maintain an office with a telephone in the company's name where Contractor conducts business. The office shall be staffed during the hours of 8:00 a.m. to 5:00 p.m., Monday through Friday, by at least one employee who can respond to inquiries and complaints which may be received about the Contractor's performance of the Agreement. When the office is closed, an answering service shall be provided to receive calls.

8.9 Additional Covenants of Contractor: In performing the services described in this Statement of Work, Contractor shall:

8.9.1 Have no contact whatsoever with any of the patients of County's Facilities, without the prior written consent of the Director, during the course of Contractor's performance of any of the services in this Agreement.

8.9.2 Use reasonable care to avoid duplicate invoicing.

8.9.3 If so requested in advance by County, return all the material provided by County promptly and in the same condition and sequence in which they are received.

8.9.4 Respect the confidential information with regard to County patient and Facility financial records. Contractor contractually recognizes the confidentiality of all County patient data and therefore, shall obtain/extract only that information needed to discover and generate required third-party billing information. All such collected information shall remain the property of County.

8.9.5 Upon termination of Agreement, if so requested by the Director, Contractor shall provide County, in a format designated by the Director, with the data currently maintained in performance of services under this Agreement in accordance this Statement of Work.

9.0 PERFORMANCE REQUIREMENTS SUMMARY

9.1 All listings of services used in the Performance Requirements Summary (PRS) are intended to be completely consistent with the Agreement and the Statement of Work, and are not meant in any case to create, extend, revise, or expand any obligation of Contractor beyond that defined in the Agreement and the Statement of Work. In any case of apparent inconsistency between services as stated in the Agreement and the Statement of Work and Attachment B, the PRS Chart, the meaning apparent in the Agreement and the Statement of Work will prevail. If any service seems to be created in this PRS which is not clearly and forthrightly set forth in the Agreement and the Statement of Work, that apparent service will be null and void and place no requirement on Contractor.

9.2 The Contractor is expected to perform all services described herein. The PRS Chart describes certain required services which will be monitored by the County during the term of the Agreement, and for which Contractor may be assessed financial deductions from payment if the service has not been satisfactorily provided. The PRS Chart indicates the Statement of Work and/or Agreement section of the performance referenced (column 1); the

service and expected standard to be provided (column 2); the monitoring method that will be used (column 4); and the deductions/fees to be assessed for services that are not satisfactory (column 5).

10. PROVISION FOR PAYMENT: In accordance with the body of this Agreement, and as further set forth herein, County shall compensate Contractor as follows:

10.1 The fee payable to Contractor with respect to Medi-Cal, Medicare, health care plan and commercial insurance, and other third-party payer payments received by County as a consequence of this Exhibit A-1, Statement of Work, Sections 3.1-EDICS, 3.2- FBFS, 3.3-TPRIRS, and 3.5-UAIBS shall be negotiated by the Director and the Contractor but not be greater than the amounts identified on Attachment C, Fee Schedule Maximum Amounts. The negotiated fees will be incorporated into this Agreement via a written change notice made pursuant to Paragraph 16, Alteration of Terms, of the Agreement.

10.2 Contractor shall be paid on a contingent fee basis for MBDRS provided to the County pursuant to Exhibit A-1, Section 3.4.1- MBDRS, and shall be negotiated by the Director and the Contractor but shall not, over the term of Agreement, be greater than twenty percent (20%) of the incremental Medicare Bad Debt settlement payments received by County as a direct result of Contractor's efforts.

10.3 Contractor shall be paid on a contingent fee basis for DSRS provided to the County pursuant to Exhibit A-1, Section 3.4.2-DSRS, herein, and shall be negotiated by the Director and the Contractor but shall not, over the term of Agreement, be greater than twelve percent (12%) of the incremental (defined in Section 10.3.1 below) Medicare DSH reimbursements (an amount attributable to the Medi-Cal eligible days portion of the Medi-Cal claim) received by the County as a direct result of Contractor's efforts. The contingency fee paid to Contractor shall be calculated by each fiscal year, this amount can be calculated by dividing the Medi-Cal eligible and 1115 Waiver days ratio by the sum of the Medi-Cal, 1115 Waiver and SSI ratios. The resulting ratio will be applied to the total DSH reimbursement amount as per audit to determine the amount

attributable to the Medi-Cal eligible days. The SSI ratio is provided by The Centers for Medicare and Medicaid Services.

10.3.1 FYE June 30, 2002 and Forward – Incremental is defined as the additional Medi-Cal eligible days identified by Contractor that are greater than zero (0) due to Federal requirements of matching every Medi-Cal eligible day to the State Eligibility Verification Process or other State records that determines eligibility.

10.3.2 Claiming submitted by Contractor for cost report filings – County will pay Contractor an interim four percent (4%) contingency fee for the Medi-Cal eligible days allowed during the desk audit; however, final payment to Contractor will be determined by the actual Medi-Cal eligible days allowed at final settlement. If the final settlement reflects a reduction or increase in Medi-Cal eligible days from the eligible days allowed during the desk audit, Contractor will refund/credit or invoice the difference to County.

10.4 Contractor shall be paid on transaction fee basis for Claim Processing at the County's "SAPC Office pursuant to Section 3.1.3, herein. The transaction fee payable to Contractor with respect to MDTCP and MCECP services shall be on a claim processed basis and shall not be greater than ($2.25) for each claim processed.

10.5 Contractor shall be paid on a contingent fee basis for services provided to the County pursuant to Section 3.4.3-IMERS, herein, and shall be negotiated by the Director and the Contractor but shall not, over the term of Agreement, be greater than twenty five percent (25%) of the incremental IMERS revenue received by County as a direct result of Contractor's efforts.

10.6 All amounts payable to Contractor pursuant to this Paragraph 10, Provision for Payment, shall be paid by County to Contractor within a reasonable period of time following County's receipt of complete and

correct payments for the billings generated by Contractor. At a minimum, Contractor shall submit monthly invoices detailing the payments received from all Third Party payers during the prior month separated by facility, services, and payers. In no case shall County pay to Contractor any amounts pursuant to this Paragraph 10, Provision for Payment, for any Third Party payments received by Facilities prior to date of commencement of this Agreement. Contractor shall be entitled to payments, pursuant to this Paragraph 10, Provision for Payment, for completed services provided by Contractor on accounts which were referred to and accepted by Contractor and not recalled by County, prior to expiration or other termination of this Agreement.

All disputed accounts shall be resolved by County and Contractor as follows:

1. County will use a "Disputed Account Form" mutually agreed upon by County and Contractor.
2. Each disputed account may be returned to Contractor for additional information.
3. Contractor shall have thirty (30) days from receipt of a Disputed Account Form to respond to County's dispute.
4. County shall have thirty (30) days to accept or reject Contractor's response and process Contractor's invoice for the disputed claim. If County rejects Contractor's response and denies payment, Contractor must file an appeal to the Chief of Revenue Management for final disposition.

10.7 Contractor hereby agrees that any Payments made by County to Contractor for patient stays/visits originally approved by a Third Party payer, but later disallowed in audit or otherwise recouped by the payer or its intermediary, except for Medi-Cal cost report settlements, shall be repaid/offset to County. If Contractor fails to execute provisions of this agreement (e.g., process claims un-timely, fail to bill, etc.) resulting in lost revenue for the County, County shall have the right to recoup such revenues from future payments to Contractor or by other means deem

appropriate by County. All repayments/offsets of Payments to be made by Contractor shall be due and payable by Contractor upon Contractor's receipt of an itemized invoice indicating the specific nature and amount of the audit disallowance(s) and/or recoupment(s) and affirming County's intention to immediately repay any disallowances to the effective payer(s). If Contractor fails to immediately reimburse County following its receipt of such invoice, Director may, at his or her sole discretion, deduct such amount from future payments to Contractor.

10.8 Contractor hereby agrees that should it become necessary, due to temporary failure of Contractor to provide adequate EDICS, Contractor shall not be entitled to receive any fees specified in this Paragraph for claims submitted for payment through alternative means. Contractor shall be responsible for all lost revenue resulting from its failure to provide EDICS and if necessary, establish or subcontract with a qualified alternative third party to provide EDICS.

10.9 Contractor also agrees to maintain records sufficient to document all billings submitted as part of this Agreement. Those records shall serve as the basis of the computations required pursuant to paragraph 10 - Provision for Payment and shall contain the following information:

1. Accounts billed;
2. Invoice/control numbers of all billings submitted;
3. Dates of billings;
4. Amounts paid to County, by invoice/control number;
5. Dates of payments to County;
6. Amounts due to Contractor;
7. Dates of payments to Contractor by County; and
8. Account Notes.

County shall cooperate in providing Contractor with access to the information necessary for Contractor to maintain such ledgers and Contractor shall make such ledgers available to County for its inspection.

11. Special Accounts: In the event the County identifies services substantially similar to those provided by Contractor, the Director may assign special

accounts to the Contractor, pursuant to Paragraph 16, Alteration of Terms, subparagraph B.

FACILITIES LIST

DETAILED LISTING OF COUNTY FACILITIES
BY NETWORKS AND CLUSTERS

Health Services Headquarters/Administration (HSA)

Facility	Location
Health Services Administration (HSA) Building	313 N. Figueroa St. Los Angeles, CA 90012
Ferguson Building	5555 Ferguson Dr., Commerce, CA 90022
Emergency Medical Services (EMS) Agency	10100 Pioneer Blvd. Suite 200 Sante Fe Springs, CA 90670

LAC+USC HEALTHCARE NETWORK

Facility	Location
LAC + USC Medical Center	1200 North State St. Los Angeles, CA 90033
Edward R. Roybal CHC	245 South Fetterly Ave. Los Angeles, CA 90022
El Monte CHC	10953 Ramona Blvd. El Monte, CA 91731
H. Claude Hudson CHC	2829 South Grand Ave. Los Angeles, CA 90077
La Puente HC	15930 Central Ave. La Puente, 91744
Juvenile Court Facility	
Central Juvenile Hall	1605 Eastlake Ave. Los Angeles, CA 90033

METROCARE NETWORK - COASTAL CLUSTER

Facility	Location
Harbor/UCLA Medical Center	1000 West Carson St. Torrance, CA 90509
Long Beach CHC	1333 Chestnut Ave. Long Beach, CA 90813
Bellflower HC	10005 East Flower St Bellflower, CA 90706
Wilmington HC	1325 Broad Ave. Wilmington, CA 90744

METROCARE NETWORK - SOUTHWEST CLUSTER

Facility/Structure	Location
MLK Multi-service Ambulatory Care Center (MACC)	12021 S. Wilmington Ave. Los Angeles, CA 90059
Hubert H. Humphrey CHC	5850 South Main St. Los Angeles, CA 90003
Dollarhide HC	1108 North Oleander St. Compton, CA 90220

Rancho Los Amigos National Rehab Center

Facility	Location
Rancho Los Amigos National Rehabilitation Center	7601 E. Imperial Highway Downey, CA 90242

VALLEY CARE NETWORK

Facility	Location
Olive View/UCLA Medical Center	14445 Olive View Drive Sylmar, CA 91342
Mid-Valley CHC	7515 Van Nuys Blvd., Van Nuys, CA 91408
San Fernando HC	1212 Pico St. San Fernando, CA 91340
Vaughn Health Center (school based)	1330 Vaughn St. Pacoima, CA 91330

HIGH DESERT HEALTH SYSTEM

Facility	Location
High Desert Health System MACC	44900 N. 60th Street, West Lancaster, CA 93336
Antelope Valley Health Center	335-B East Ave. K-6 Lancaster, CA 93535
Lake Los Angeles Community Clinic	16921 East Ave O, Space G Lake Los Angeles, CA 93591
Littlerock HC	8201 Pearblossom Highway, Littlerock, CA 93543
South Valley HC	38350 40th St. East Palmdale, CA 93552

Attachment B

PERFORMANCE REQUIREMENTS SUMMARY

FINANCIAL MANAGEMENT SERVICES

Required Service/Statement of Work Reference	Standard of Performance	Maximum Allowed Deviation (Acceptable Quality Level {AQL}) %	Typical Monitoring Method	Unsatisfactory Performance Indicator for Exceeding AQL
Exhibit A-1, Section 7.1 - Contractor is required to attend a scheduled monthly meeting, or as otherwise determined by Director	Attend required meetings as required in SOW.	None	Documenting absence in meetings.	- $100 per each meeting contractor does not attend.
Exhibit A-1, Section 7.2 - Contractor is required to respond in writing within five (5) workdays upon receipt of the Contract discrepancy report.	Provide written response and plan for correction as required by SOW.	1 business day late	Receipt written response and plan for correction	-$50 per each day late, per Facility. -$100 if correction plan is incomplete
Exhibit A-1, Section 3.3.4 - Provide Facility monthly listing of Approved Account within 7 days of 3rd party ID where payment was not received	Submit listing timely per established due date.	None	Review of reports	- $100 per day listing is not submitted by established due date.
Exhibit A-1, Section 3.3.3 - Obtain prior approval before pursuing Referred Accounts	Request approval immediately for Referred Accounts Contractor intends to pursue	None	Review of reports	- $100 per account when account is pursued without prior approval

Attachment B-1 Confidentiality	Employee Acknowledgement and Confidentiality Agreement signed and provided to DHS within three (3) business days.	None	Review of reports, complaints	- $100 per day per employee when form not signed - $1,000 per unauthorized release of information
Exhibit A-1, Section 6.0 - Maintain written Quality Control Plan	Quality Control Plan maintained and provided as required	1 business day late	Receipt and review of plan	-$50 per each day late. -$100 if plan is incomplete
Exhibit A-1, Section 8.4.4 – Respond to County Inquiries	Respond to inquiries within 24 hours	1 business day late	Review of the inquiries	-$100 per day when timeframe is not adhered to.
Exhibit A-1, Section 2.2 Referred Accounts Recalled	Stop collection activities immediately and return account to County within five (5) business days.	1 business day late	Review of accounts and reports	- $100 per account per each day not returned.
Exhibit A-1, Section 3.1.1.5, 3.2.11, 3.3.13, 3.5.11 - Post account adjustments	Adjustments are posted within two (2) business days upon completion of payment, adjustment, account status change, etc.	1 business day late	Patient complaints, management reports, review accounts during on-site audits	- $100 per each day posting is late.
Exhibit A-1, Section 4 - Provide required reports	Provide various management reports timely per established due	1 business day late from due date	Review of Reports	-$100 per incomplete/inaccurate reports. -$50 per report per each day late
Exhibit A-1, Section 3.1.3.3 - Provide back eligibility status within 3 business days that eligibility information was received from SAPC.	Provide back eligibility status with 3 business days	None	Review of Reports	-$100 per day late

ATTACHMENT B-1

EXHIBIT G2

CONTRACTOR EMPLOYEE ACKNOWLEDGEMENT AND CONFIDENTIALITY AGREEMENT

(Note: This certification is to be executed and returned to County with Contractor's executed Agreement. Work cannot begin on the Agreement until County receives this executed document.)

Contractor Name _____ Agreement No._____

Employee Name _____

GENERAL INFORMATION:

Your employer referenced above has entered into an Agreement with the County of Los Angeles to provide certain services to the County. The County requires your signature on this Contractor Employee Acknowledgement and Confidentiality Agreement.

EMPLOYEE ACKNOWLEDGEMENT:

I understand and agree that the Contractor referenced above is my sole employer for purposes of the above-referenced Agreement. I understand and agree that I must rely exclusively upon my employer for payment of salary and any and all other benefits payable to me or on my behalf by virtue of my performance of work under the above-referenced Agreement.

I understand and agree that I am not an employee of the County of Los Angeles for any purpose whatsoever and that I do not have and will not acquire any rights or benefits of any kind from the County of Los Angeles by virtue of my performance of work under the above-referenced Agreement. I understand and agree that I do not have and will not acquire any rights or benefits from the County of Los Angeles pursuant to any agreement between any person or entity and the County of Los Angeles.

I understand and agree that I may be required to undergo a background and security investigation(s). I understand and agree that my continued performance of work under the above-referenced Agreement is contingent upon my passing, to the satisfaction of the County, any and all such investigations. I understand and agree that my failure to pass, to the satisfaction of the County, any such investigation shall result in my immediate release from performance under this and/or any future Agreement.

CONFIDENTIALITY AGREEMENT:

I may be involved with work pertaining to services provided by the County of Los Angeles and, if so, I may have access to confidential data and information pertaining to persons and/or entities receiving services from the County. In addition, I may also have access to proprietary information supplied by other vendors doing business with the County of Los Angeles. The County has a legal obligation to protect all such confidential data and information in its possession, especially data and information concerning health, criminal, and welfare recipient records. I understand that if I am involved in County work, the County must ensure that I, too, will protect the confidentiality of such data and information. Consequently, I understand that I must sign this agreement as a condition of my work to be provided by my employer for the County. I have read this agreement and have taken due time to consider it prior to signing.

I hereby agree that I will not divulge to any unauthorized person any data or information obtained while performing work pursuant to the above-referenced Agreement between my employer and the County of Los Angeles. I agree to forward all requests for the release of any data or information received by me to my immediate supervisor.

I agree to keep confidential all health, criminal, and welfare recipient records and all data and information pertaining to persons and/or entities receiving services from the County, design concepts, algorithms, programs, formats, documentation, Contractor proprietary information and all other original materials produced, created, or provided to or by me under the above-referenced Agreement. I agree to protect these confidential materials against disclosure to other than my employer or County employees who have a need to know the information. I agree that if proprietary information supplied by other County vendors is provided to me during this employment, I shall keep such information confidential.

I agree to report to my immediate supervisor any and all violations of this agreement by myself and/or by any other person of whom I become aware. I agree to return all confidential materials to my immediate supervisor upon completion of this Agreement or termination of my employment with my employer, whichever occurs first.

SIGNATURE: _____ DATE: ____/____/____

PRINTED NAME: _____

POSITION: _____

ATTACHMENT C

COUNTY OF LOS ANGELES
SUTHERLAND GLOBAL SERVICES AGREEMENT
FEE SCHEDULE MAXIMUM AMOUNTS
FOR EXHIBIT A-1 PROVISIONS 3.1 EDICS, 3.2 FBFS, 3.3 STPRIR, 3.4 CRRS AND 3.5 UAIBS

CONTRACT PROVISION	MEDI-CAL	MEDICARE	Crossover Medi-Cal Portion	INSURANCE	ALL OTHER PAYORS
3.1 EDICS	No greater than $5 for each paid claim	No greater than $5 for each paid claim	No greater than $5 for each paid claim	No greater than $5 for each paid claim	No greater than $5 for each paid claim
3.2 FBFS	No greater than: $86 per I/P paid day, $14 per O/P paid visit	No greater than 15.5% of payments received	No greater than: $86 per I/P paid claim, $7 per O/P paid claim	No greater than 14% of payments received	No greater than 15.5% of payments received
3.3 TPRIRS	No greater than: $345 per I/P paid day, $28 per O/P paid visit	No greater than 25% of payments received	No greater than: $173 per I/P paid claim, $14 per O/P paid claim	No greater than 25% of payments received	No greater than 25% of payments received
3.4 CRRS	No greater than 12% of payments received	No greater than 25% of payments received	No greater than 12% of payments received	No greater than 25% of payments received	No greater than 25% of payments received
3.4 UAIBS	No greater than: $345 per I/P paid day, $28 per O/P paid visit	No greater than 25% of payments received	No greater than: $173 per I/P paid claim, $14 per O/P paid claim	No greater than 25% of payments received	No greater than 25% of payments received

Notes:
I/P = Inpatient
O/P = Outpatient

3.2. FBFS and 3.3 TPRIRS there is a CAP of $19,500 per paid account.

EXHIBIT II

H-702058-4

FINANCIAL BILLING AND RECOVERY SERVICES AGREEMENT

AMENDMENT NO. 4

THIS AMENDMENT is made and entered into this _____ day of _____, 2013,

by and between COUNTY OF LOS ANGELES (hereafter "County"),

and USCB, INC. (hereafter "Contractor").

WHEREAS, reference is made to that certain document entitled "FINANCIAL BILLING AND RECOVERY SERVICES AGREEMENT", dated July 1, 2006, and further identified as County Agreement No. H-702058 and any Amendments thereto (all hereafter "Agreement"); and

WHEREAS, it is the intent of the parties hereto to amend the Agreement to extend the term, and reflect any changes described hereinafter; and

WHEREAS, Agreement provides that changes may be made in the form of a written Amendment which is formally approved and executed by both parties.

NOW THEREFORE, the parties hereby agree as follows:

1. This Amendment shall become effective on the date of its approval by County's Board of Supervisors, with such date reflected on the top of page 1 of Amendment.

2. Subject to the provisions of the Agreement, this Agreement shall continue in full force and effect up to and including May 31, 2015.

3. Paragraph 1, TERM, paragraph 1, shall be revised to read as follows:

"1. TERM: The term of this Agreement shall commence on July 1, 2006, and shall continue, in full force and effect, through and including May 31, 2015.

The County shall have the sole option to extend this Agreement term for up to two additional one-year periods, beginning June 1, 2015 through May 31, 2017, with the exercise of such option subject to Board approval in accordance with Paragraph 14, Amendments.

The County maintains databases that track/monitor Contractor performance history. Information entered into such databases may be used for a variety of purposes, including determining whether the County will exercise a contract term extension option.

The Contractor shall notify DHS when this Agreement is within six (6) months from the expiration of the term as provided for hereinabove. Upon occurrence of this event, the Contractor shall send written notification to the DHS at the address provided in Paragraph 18, Notices, of the Agreement."

4. Paragraph 6, GENERAL INSURANCE REQUIREMENTS, Subparagraph A. (3) shall be replaced in its entirety to now read as follows:

"(3). Cancellation of or Changes in Insurance

Contractor shall provide County with, or Contractor's insurance policies shall contain a provision that County shall receive, written notice of cancellation or any change in Required Insurance, including insurer, limits of coverage, term of coverage or policy period. The written notice shall be provided to County at least ten (10) days in advance of cancellation for non-payment of premium and thirty (30) days in advance for any other cancellation or policy change. Failure to provide written notice

of cancellation or any change in Required Insurance may constitute a material breach of the Contract, in the sole discretion of the County, upon which the County may suspend or terminate this Contract."

5. Paragraph 6, GENERAL INSURANCE REQUIREMENTS, Subparagraph C, Failure to Maintain Coverage, is deleted in its entirety and replaced by the following:

"C. Failure to Maintain Insurance

Contractor's failure to maintain or to provide acceptable evidence that it maintains the Required Insurance shall constitute a material breach of the Contract, upon which County immediately may withhold payments due to Contractor, and/or suspend or terminate this Contract. County, at its sole discretion, may obtain damages from Contractor resulting from said breach. Alternatively, the County may purchase the Required Insurance, and without further notice to Contractor, deduct the premium cost from sums due to Contractor or pursue Contractor reimbursement."

6. Except for the changes set forth herein above, Agreement shall not be changed in any respect by this Amendment.

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IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles

has caused this Amendment to be executed by the County's Director of Health Services and Contractor has caused this Amendment to be executed in its behalf by its duly authorized officer, the day, month, and year first above written.

COUNTY OF LOS ANGELES

By _____
Mitchell H. Katz, M.D.
Director of Health Services

USCB, INC.
Contractor

By _____
Signature

_____
Print Name

Title _____

APPROVED AS TO FORM
BY THE OFFICE OF THE
COUNTY COUNSEL